RIDE CALHOUN

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ADA APPLICANT AUTHORIZATION FOR HEALTH CARE PROVIDER
RELEASE OF INFORMATION

In order for Ride Calhoun to evaluate your request for paratransit service certification, it may be necessary to contact a health care professional for additional information about your disability and the ability to use the regular fixed route service. It is important that you identify a professional who is familiar not only with your disability, but who also understands your ability or inability to travel on the accessible fixed route system.
Please complete, sign, and return with your application, in the event we need to contact your healthcare provider.

Health Care Professional Information

Name of Professional:_____
Health Organization:_____
Address:_____
City/State/Zip:_____
Phone:_____

Please check the health care profession of the above-noted individual:

____Physician
____Psychologist / Psychiatrist
____Rehabilitation Specialist
____Voc. Rehabilitation Counselor
____Registered Nurse
____Occupational Specialist
____Independent Living Specialist
____Social Worker
____Other: _____

I authorize my noted health care professional to release to Ride Calhoun, information about my disability and its affects on my ability to travel on the fixed route system. This information may be needed in connection to my request for paratransit eligibility certification. It is my understanding that the information will be used solely to determine my eligibility. I understand that I may revoke this authorization at any time.

Applicant Signature:_____Date:_____